Changes in HMO Enrollment Related to Increased Consumer Cost Sharing Provisions in MCL 500.3515

prepared for

State of Michigan
Office of Financial and Insurance Regulation
Department of Labor and Economic Growth

prepared by

Elliot K. Wicks, Ph.D.

Health Management Associates

May 2008

Acknowledgements

The author thanks Chris Nettleton of the Michigan Office of Financial and Insurance Regulation for help in compiling and interpreting insurance company data and Richard Murdock of the Michigan Association of Health Plans and numerous Michigan health plan officials and executives and insurance agents for helping in understanding the insurance market in Michigan.

INTRODUCTION

Public Act 306, enacted by the Michigan Legislature in 2005, gave health maintenance organizations (HMOs) greater flexibility in the way they could structure their benefit plans. Upon the enactment of the legislation, HMOs were permitted to market policies that require insured people to pay more of the cost at the time they consume health services. Specifically, the act allowed HMOs to impose higher copayments and higher coinsurance. The specific language was as follows:

> Sec. 3515. (2) A health maintenance organization may have health maintenance contracts with deductibles. A health maintenance organization may have health maintenance contracts that include copayments, stated as dollar amounts for the cost of covered services, and coinsurance, stated as percentages for the cost of covered services. Coinsurance for basic health services, excluding deductibles, shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee and shall not be based on the provider's standard charge for the service. This subsection does not limit the commissioner's authority to regulate and establish fair, sound, and reasonable copayment and coinsurance limits including out of pocket maximums.

The legislation also required the commissioner to prepare a report to determine whether giving HMOs this greater flexibility increased their ability to attract new employers and to increase enrollment. The specific language is as follows:

> Sec. 3515. (3) By May 15, 2008, and by each May 15 after 2008, the commissioner shall make a determination as to whether the greater copayment and coinsurance levels allowed by the amendatory act that added this subsection have increased the number of employers who have contracted for health maintenance organization services and whether these levels have increased the number of enrollees receiving health maintenance organization services. In making this determination, the commissioner shall hold a public hearing by February 1, 2008, and may hold a public hearing thereafter, shall seek the advice and input from appropriate independent sources, including, but not limited to, all health maintenance organizations operating in this state and with enrollees in this state, and shall issue a report delineating specific examples of copayment and coinsurance levels in force and suggestions to increase the number of persons enrolled in health maintenance organizations.

The purpose of this report is to meet the legislative requirement for an assessment of the effects of giving HMOs more latitude in defining benefit packages.

Historical Context

The apparent intent of this legislation was to make HMOs more competitive with other kinds of health insurance. To understand why the legislation might be expected to achieve this result, it is useful to review some of the history of HMOs.

Traditional "old style" health maintenance organizations were highly integrated delivery systems based around a panel of physicians in a group practice. Kaiser Permanente, Group Health of Puget Sound, and Health Central in Lansing[1] (one of the first HMOs in Michigan) were examples of such traditional HMOs. These HMOs depended upon a high degree of integration of services and personnel to control utilization and costs. The view was that carefully selected physicians, usually working exclusively for the HMO, were in the best position to make good decisions about which kind and how many medical services were appropriate and cost effective in meeting patients' needs, and that costs could be controlled by careful management of patients and their care. Moreover, because physicians were not paid on a fee-for-service basis and were either salaried or financially rewarded for being economical in treating patients, the incentives discouraged excess utilization. Thus the thinking was that significant consumer cost-sharing through the use of deductibles and co-insurance was not necessary to control costs and, in fact, would be counterproductive by discouraging patients from utilizing preventive and other health maintenance services that were highly beneficial and cost effective. This view seemed to be proved by the utilization and cost experience of such HMOs, since their use of expensive services, particularly hospital days, was generally much lower than traditional fee-for-service medicine. Consequently, their costs and premiums were significantly lower than traditional indemnity insurance plans.

Hence, the early HMOs did not have any significant degree of cost-sharing, and that principle was built into the original Michigan HMO laws, which severely limited the extent to which HMOs could impose consumer cost-sharing requirements—deductibles, copayments, and coinsurance. Times change, however. HMOs' success in controlling costs led other insurers to adopt some of the cost control practices that seemed to be effective. Preferred provider organizations (PPOs) appeared, offering some of the opportunities for managing care available to HMOs but without the severe constraints on consumers' choice of providers. As a result of these and other changes in the insurance market, the cost advantage of traditional HMOs was diminished, and the greater latitude in choosing providers that PPOs offered was attractive to consumers. As a consequence, PPOs started gaining market share, sometimes at the expense of HMOs.

At the same time, non-HMO insurers were increasing the extent of consumer cost-sharing in their benefit plans. One objective, of course, was to reduce insurers' claims payout and allow them to offer benefit plans with lower premiums, thus making them more attractive to cost-conscious employers. Another objective was to create incentives for consumers to be more economical in their use of medical services. This change was particularly promoted by advocates of consumer-directed health plans and medical savings accounts, who were convinced that high deductibles and other consumer cost-sharing would make con-

[1] Health Central was ultimately acquired by Blue Cross and Blue Shield of Michigan and absorbed into their HMO system.

sumers more cost-conscious and deter them from seeking some medical services that they otherwise would have consumed.

These developments, along with the legal prohibition on significant consumer cost-sharing, put HMOs at a price disadvantage, for which they sought legislative relief. The legislature apparently concluded that if HMOs were to be able to offer competitive premiums, they needed to have the ability to develop benefit plans that included significant consumer cost-sharing.[2] The first effort to give HMOs greater flexibility to require enrollees to pay more of the cost of services was the passage of Public Act 621 in 2002. That legislation for the first time gave HMOs the authority to sell plans that included significant deductibles:

> Sec. 3515 (2). A health maintenance organization may have health maintenance contracts with deductibles. A health maintenance organization may have health maintenance contracts with copayments that are required for specific health maintenance services. Copayments for services required under section 3501(b), excluding deductibles, shall be nominal, shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee, and shall not be based on the provider's standard charge for the service. A health maintenance organization shall not require contributions be made to a deductible for preventative health care services. As used in this subsection, "preventative health care services" means services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability.

In addition to allowing HMOs for the first time to offer policies with deductibles, this provision of the law allowed HMOs to have copayments, but they had to be "nominal."

The passage of Public Act 360 in 2005 further extended HMOs' flexibility to establish health plans that required consumer cost-sharing. Section 500.3515 permitted HMOs to market benefit plans with not just the "nominal" cost-sharing that was previously permitted but substantial copayments and coinsurance as well. (Prior to the new law, OFIR guidelines defined "nominal" as meaning that copayments and coinsurance out-of-pocket maximums could not exceed $3,000 for an individual and $6,000 per family.) The expectation was that allowing HMOs to offer benefits plan with greater consumer cost-sharing would lower premiums, making HMOs more attractive to employers and their employees and thereby increasing enrollment in HMOs.

[2] There are essentially three kinds of consumer cost-sharing. *Deductibles* refer to amounts that consumers must pay out of pocket for medical services as a whole before the insurance coverage pays anything. Sometimes, however, coverage will pay for some services, such as preventive care, before consumers have exceeded the deductible amount. *Coinsurance* and *copayments* apply at the time when an insured person consumes a particular medical service. Copayments are fixed-dollar amounts per service, whereas coinsurance is a percentage of the service cost.

THE STUDY FINDINGS

The apparent purpose of the legislative change was to allow HMOs to compete more effectively with non-HMO plans that were selling policies with greater consumer cost-sharing. These plans require consumers to pay more of the cost of medical services they consume, so, of course, the premiums are lower, making them more attractive to employers and perhaps to employees as well. If the legislation were to achieve its intended purpose, HMOs would be expected to gain enrollment relative to the rest of the market and to reverse or moderate the trend of falling commercial enrollment, which began in 2000.

To gather data to assess the effects of the changed law, the Office of Financial and Insurance Regulation (OFIR) in 2007 required Michigan HMOs to complete a special form to report enrollment changes since the law went into effect in 2005. The HMOs were asked to report how the ability to market plans that included more consumer cost-sharing affected sales of their commercial business, that is, sales to employer groups both large and small. (Enrollment in self-insured plans is not included, because the legislation was not applicable to this sector of the market, which is technically not insurance.)

Table 1 below is a compilation of the data from that survey. It is clear that the increased flexibility has not resulted in an increase in HMO enrollment. Of the 10 HMOs still selling commercial coverage in the state, all but three experienced a decline in enrollment during the period. The number of insured groups fell by 2,248, a 10.1 percent drop; and the number of enrollees declined by 86,495, a 5.2 percent drop. The decline did not begin with the change in the law regarding cost-sharing, however. Commercial enrollment has been declining since 2000. Looking at the enrollment data alone would suggest that the legal change has not helped HMOs become more competitive.

The survey asked HMOs to report how the increased flexibility affected their product offerings and take-up of new products. Their responses confirm the conclusion that the legal change had little effect, at least through 2007. OFIR asked HMOs to identify newly offered products that have "annual copayments and coinsurance exceeding the previous general guidance level of $3,000 for individuals and $6,000 for families." (It should be noted that OFIR considered copayments and coinsurance below these levels to conform to the previous legislative language that allowed only "nominal" payments by consumers. This was a generous interpretation of the law because not many policies include such substantial cost-sharing even now, and it helps to explain the findings below that raising these limits did not have much effect.)

TABLE 1

HMO REPORTS OF CHANGES IN ENROLLMENT DUE TO 2005 LEGISLATIVE CHANGES RELATED TO CO-INSURANCE AND CO-PAYMENTS, 2005-2007

Health Plan	Commercial Employer Groups					Commercial Enrollees					Response to New Law Provisions*
	12/31/05	9/30/07	Change	% Change	Increase Due to Law Change*	12/31/05	9/30/07	Change	% Change	Increase Due to Law Change*	
Blue Care Network of Michigan	7,450	7,928	478	6.4%		430,120	476,857	46,737	10.9%		No high cost-sharing plans
Grand Valley Health Plan	269	187	-82	-30.5%	1	15,546	9,689	-5,857	-37.7%	2	1 certificate, 12 riders; 8 not sold
Health Alliance Plan	2,412	2,010	-402	-16.7%		453,837	408,877	-44,960	-9.9%		10 offered, none sold
Priority Health	6,847	6,495	-352	-5.1%	0	370,199	391,011	20,812	5.6%	0	1 plan for a specific employer, but not sold
Physicians Health Plan of Mid-Michigan	1,219	877	-342	-28.1%	0	72,755	49,231	-23,524	-32.3%	0	
Paramount Care of Michigan, Inc.	255	297	42	16.5%	14	7,081	7,165	84	1.2%	126	Offered 3 plans
HealthPlus of Michigan, Inc.	819	714	-105	-12.8%	0	83,590	72,198	-11,392	-13.6%	0	
M-CARE	1,652	575	-1,077	-65.2%		180,549	121,307	-59,242	-32.8%		No new products
Physicians Health Plan of Southwest Michigan	30	0	-30	-100.0%		707		-707	-100.0%		
Physicians Health Plan of South Michigan	1,063	623	-440	-41.4%		28,004	17,461	-10,543	-37.6%		No high cost-sharing plans created
Total Health Care USA, Inc.	310	372	62	20.0%		9,152	11,249	2,097	22.9%		Not clear, maybe 1 plan
TOTALS	22,326	20,078	-2,248	-10.1%	15	1,651,540	1,565,045	-86,495	-5.2%	128	

*Some HMOs left certain items blank, which is reflected in the blanks in the column.

Source: Health Management Associates compilation of results from the survey sent to the Michigan HMOs by the Office of Financial and Insurance Regulation, 2007.

The last column in the table summarizes the actions the HMOs took after gaining the new flexibility. Four of the plans that responded to this question indicated they had not introduced new benefit plans with higher cost-sharing as a result of the law change. Four HMOs did develop new plan offerings to take advantage of the law, but very few of these plans were purchased. Only two HMOs, Paramount Care of Michigan and Grand Valley Health Plan, reported that they had sold any new plans, and the number of groups purchasing them (15) and the number of people enrolling in them (128) was very small relative to total HMO enrollment.

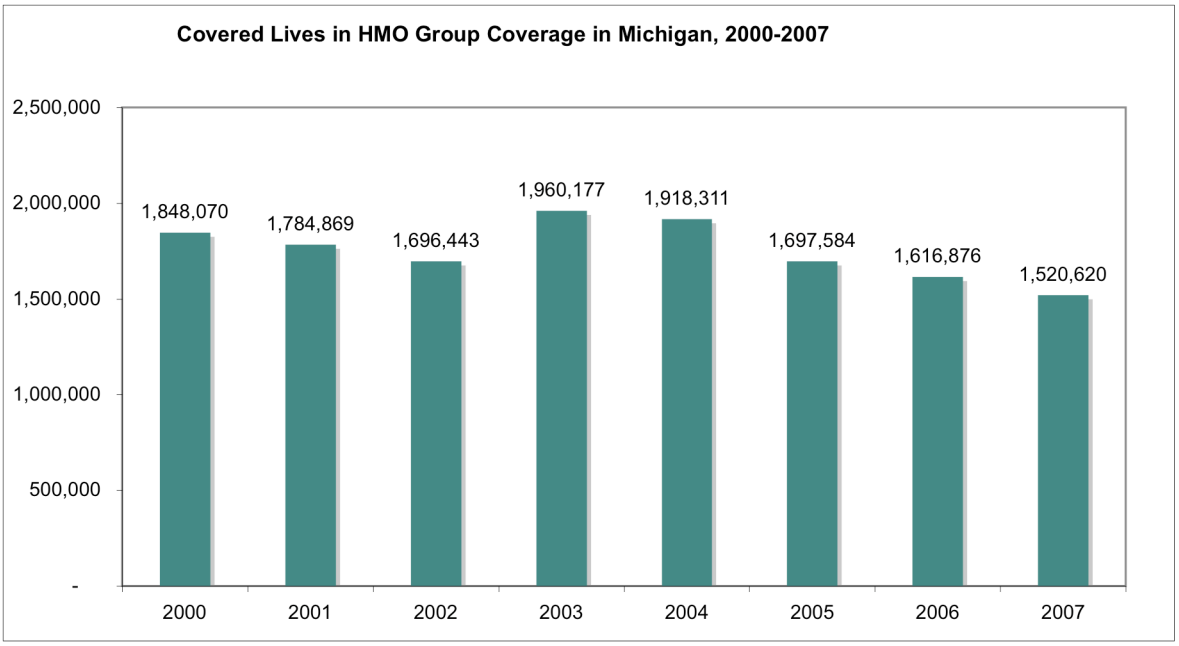
The testimony at the January 30, 2008, public hearing that was part of the process for assessing the effect of Public Act 306 confirms that most HMOs have not changed to offering benefit structures with high levels of coinsurance and copayments. Only the Michigan Association of Health Plans testified at the hearing, and the association's representative provided data that indicates copayments and coinsurance levels are still quite moderate.

Putting the Enrollment Record in Perspective

It is clear that the legislative changes made in 2005 have not produced greater enrollment for HMOs in Michigan. In fact, enrollment levels and the number of policies sold have declined, as shown above. But it would be a mistake to conclude that the legislative changes of 2005 have contributed to the decline, because that decline began several years earlier, as shown in Figure 1 below. (The enrollment data include only policies sold to commercial employer groups—small and large employers; not counted are enrollees who buy coverage as individuals or who are enrolled in HMOs through Medicaid and Medicare.)

The data provided in the tables below need to be interpreted with considerable caution. We compiled the summaries for each year from the report that OFIR collects from each health insurer and health plan in the state. But there are significant problems with the data. In some years, health plans responding to the survey submitted data that upon careful inspection is clearly incorrect because the numbers are internally inconsistent or vastly different from previous years' reporting. And data for some health plans is missing for some years. With the assistance of OFIR personnel, we tried to get corrected data where possible, and we made other efforts to try to adjust for such reporting problems; but it would be a mistake to assume the numbers are precise. Some inaccuracies surely remain. However, we are confident that the general *trends* do represent reality.

FIGURE 1



Source: Compiled by Health Management Associates based on data collected by the Michigan Office of Financial and Insurance Regulation on Form FIS 322, "Michigan Health Insurance Enrollment, Premiums and Losses."

Clearly, the number of employees enrolling in HMOs has declined in recent periods. But the same kind of enrollment decline has been experienced by other kinds of health insurers who compete in this market. Figures 2 and 3 below show that both Blue Cross and Blue Shield of Michigan and the commercial health insurers operating in the state have experienced a drop-off of enrollment at essentially the same time as HMO enrollment was declining. (Recall that the enrollment figures exclude individual market, Medicaid, and Medicare enrollment. Also note that the data accuracy problems previously described were especially evident in the data for commercial health insurers; so it is particularly important to avoid the conclusion that the year-by-year enrollment changes are accurate. In Figure 3, the large enrollment decrease for commercial insurance between 2002 and 2003 is likely a reflection of data reporting inconsistency and errors.)

Because enrollment in all types of employer-sponsored insurance has declined, HMO coverage as a portion of the total has not fared badly. As Figure 4 below shows, HMO enrollment as a portion of total employer enrollment has changed little in the last five years.

FIGURE 2

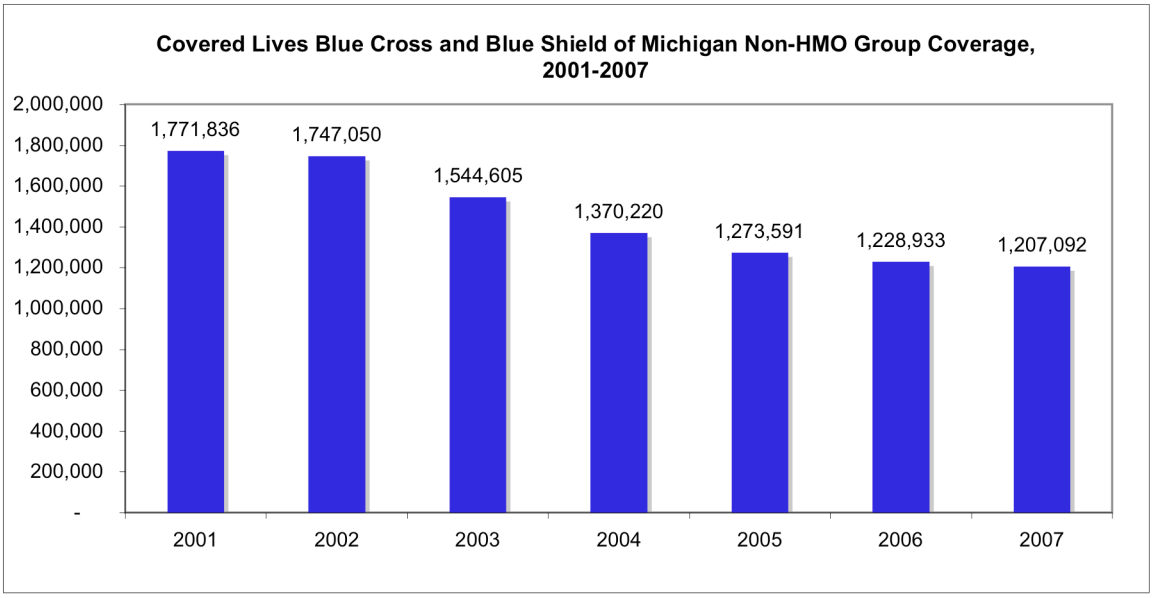
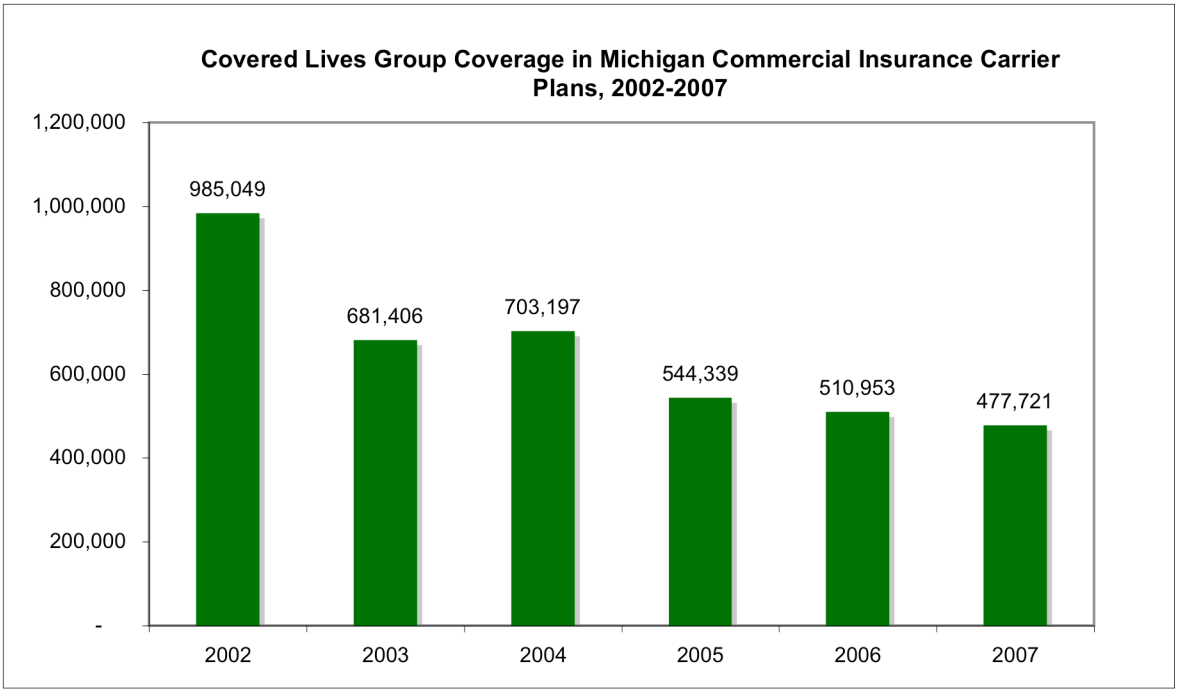
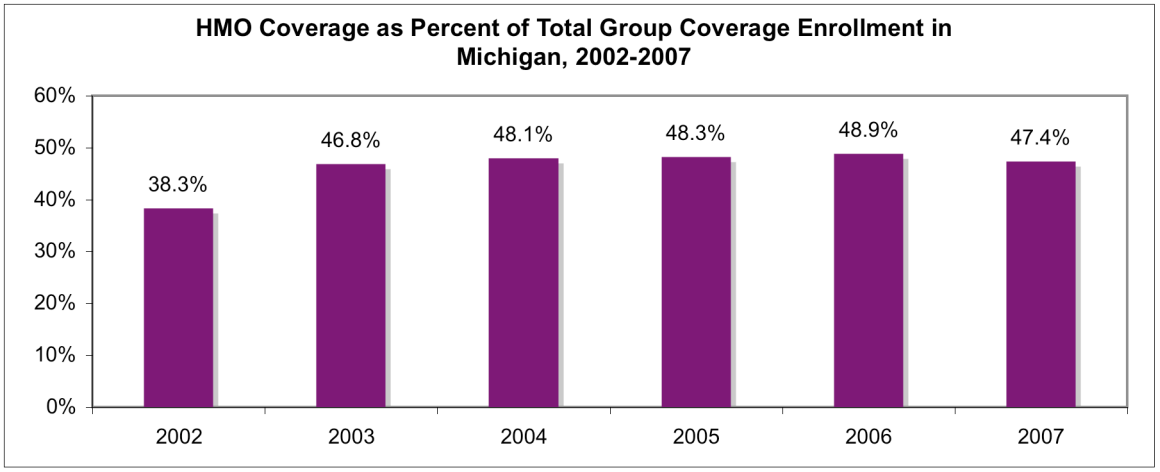


FIGURE 3



Source (for Figures 2 and 3): Compiled by Health Management Associates based on data collected by the Michigan Office of Financial and Insurance Regulation on Form FIS 322, "Michigan Health Insurance Enrollment, Premiums and Losses."

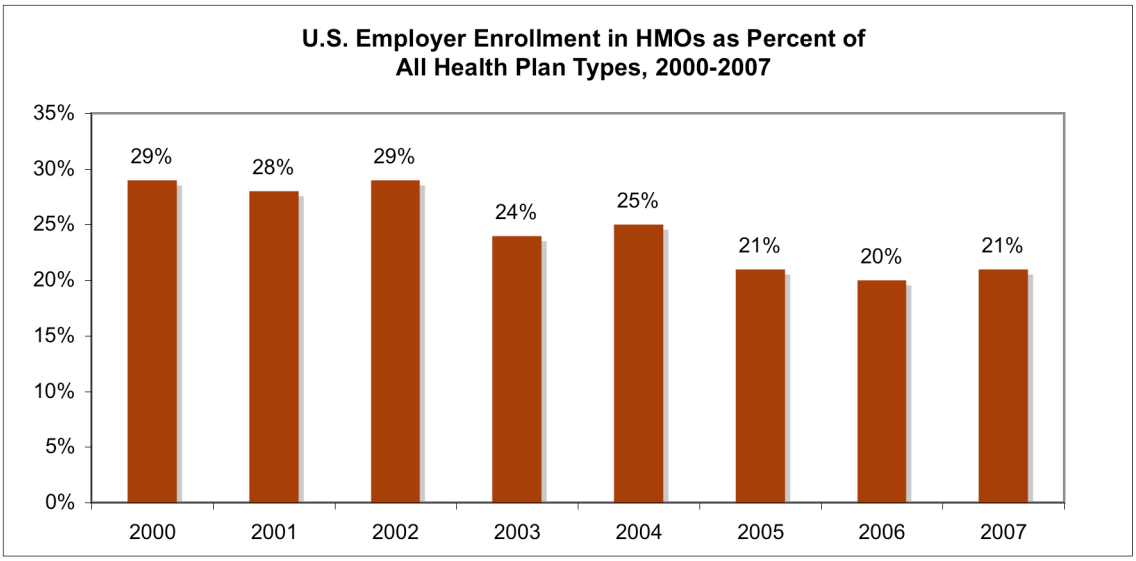
FIGURE 4



Source: Compiled by Health Management Associates based on data collected by the Michigan Office of Financial and Insurance Regulation on Form FIS 322, "Michigan Health Insurance Enrollment, Premiums and Losses."

To put the enrollment data for Michigan HMOs in perspective, we provide data in Figure 5 below showing how enrollment of employees in HMOs in the United States has changed from 2000 to 2007. In the country as a whole, HMOs are accounting for a decreasing share of enrollees covered through employer-sponsored health insurance. In comparison, Michigan HMOs seem relatively successful in maintaining market share (Figure 4).

FIGURE 5



Source: Kaiser Family Foundation, *Employer Health Benefits 2007 Annual Survey, 2007.*

RESPONSES FROM HMO EXECUTIVES, HEALTH PLAN OFFICIALS, AND AGENTS

We interviewed a number of HMO executives and officials as well as insurance agents to gain a fuller understanding of how the greater flexibility to use consumer cost-sharing has affected the kinds of policies that HMOs offer their customers. Although a few respondents indicated that they were offering plans with levels of coinsurance and copayments newly permitted under Public Act 306, the consensus is that the ability to offer plans with higher deductibles is more important than the flexibility to increase coinsurance and copayments. Many HMOs appear to be offering some health plans with higher levels of deductibles, and they think that it is important to have the flexibility to do so. A few HMOs are developing benefit plans with copayments and coinsurance that exceed the previously allowed amount of $3,000 for individuals and $6,000 for families, but most have not done so yet.

There is agreement that market demand drives the kinds of benefit structures that health plans offer. HMOs respond to what employers and employees want. Some of the HMO officials we interviewed indicated that there was not a significant market demand for HMO policies with high levels of coinsurance and copayments. They noted that Michigan has a history of offering generous policies with comprehensive benefits, and policies that are substantially less generous are not very attractive to most employers and their employees. In fact, one health plan official indicated that in some instances employers have actually chosen to drop coverage rather than switch to a plan with high consumer cost-sharing. Several of those we interviewed also pointed out that the kinds of plans offered by Blue Cross and Blue Shield of Michigan tend to set the standard for the market as a whole, and that most BCBSM plans continue to be comprehensive. One or two HMO officials also acknowledged that there is something of a conflict between the traditional concept of an HMO and HMO benefit plans that include high levels of consumer cost-sharing, but they still wanted the flexibility to offer plans with high cost-sharing along with more traditional HMO coverage. No one we spoke to appeared to believe that the legislative changes with respect to consumer cost-sharing had had a deleterious effect, even though most acknowledged that there were as yet only limited positive effects.

Despite the fact that most HMOs have not sold many plans with the levels of consumer copayments and coinsurance now permitted, several insurance agents and HMO officials and executives stressed that having this flexibility could be important in the future. As the costs of health insurance continue to outpace the rate of growth of the economy as a whole, employers and employees find coverage less affordable. Insurers will be under increasing

pressure to reduce the rate of premium escalation. As one big-company official said, "Price is king in Michigan," and agents confirm this judgment. Offering plans with greater consumer cost-sharing is one way to hold down premiums, although such an approach really amounts to shifting the cost to those who must use expensive medical services. One HMO official noted that it is important to be able to offer plans with higher co-insurance and co-payments to match the "product depth" of non-HMO competitors. Being able to do so is sometimes a condition for getting employers to consider the HMO product, even if the employer ultimately selects a plan with lower cost-sharing. Employers want to know the range of options, including plans with high cost-sharing.

Some HMOs report that agents are requesting plans with higher consumer cost-sharing in the hope that this will help them retain some customers who cannot afford their existing benefit plans. And some agents report that they are increasingly selling HMO plans that match the cost-sharing levels of the PPOs that are competing to attract employers. An agent in Genesee County reported that he encourages small employers to offer a dual option, where employees can choose either an HMO or a PPO, and in those circumstances he strongly recommends that the employer have the same cost-sharing levels for each option, with the exception that cost-sharing for preventive care is usually nominal in the case of the HMO. He notes that the employers are choosing higher and higher levels of cost-sharing, especially deductibles, as a way of keeping the premium affordable for the firm and their employees, and he thinks that this trend will continue.[3]

Other health plans officials noted that as inflation affects the economy as a whole, higher levels of consumer cost-sharing will be necessary just to maintain the same relative "real" level of cost-sharing as in the past. So it is important not to be tied to a fixed-dollar constraint.

[3] Several agents reported that it is common for employers choosing high cost-sharing plans to agree to pay for much of the cost-sharing amount for those employees who incur high medical costs. (In fact, vendors are appearing to administer such plans.) The employer evidently makes the calculation that the premium savings from buying a high cost-sharing plan more than offsets the amount the employer is likely to have to pay to cover employees' medical costs. Employers with younger, healthier employees are especially likely to adopt this strategy, according to agents we interviewed.

DISCUSSION OF POLICIES FOR INCREASING HMO ENROLLMENT

As noted earlier, HMOs in Michigan appear to have been more successful than HMOs in the country as a whole in retaining market share for commercial business. But it would probably be unrealistic to expect them to account for an increasing share of future markets. Experience across the country has shown a strong preference for health plans that give enrollees wide latitude in choosing health providers. The ability to choose one's own doctor is very important to many people, and for those who are not already in an HMO, the restriction on provider choice can make HMOs less attractive than PPOs, especially because most PPOs have very broad provider networks. Initially, HMOs were an attractive option for many employers because they were better at controlling costs, and therefore coverage was less expensive. In part, their better record in cost control was a consequence of being organized around group practices and carefully selected provider networks, which created opportunities for cost control. But over time, as more and more HMOs were organized around the independent practice association (IPA) model, with broad participation by many doctors operating in distinct and separate practices, the ability to control costs was somewhat diminished. In the meantime, PPOs were developing as a form of managed care that utilized some of the same cost control mechanisms but with fewer constraints on choice of providers. In essence, the differences between HMOs and PPOs have lessened, with important exceptions for those HMOs that are organized around tight, limited provider networks. It is perhaps not surprising, therefore, that some Michigan HMOs have developed their own PPO plans, according to some respondents that we interviewed.

Other things being equal, the present market seems to favor managed care plans that allow considerable flexibility in choice of providers and do not employ restrictive cost controls. Employees—and thus their employers—prefer plans that do not have limited services areas or restrictions on referrals to specialty services. But other things are not always equal, notably price. One health plan official with a large market share said that as a rule of thumb employers are likely to consider HMO coverage over PPO coverage when there is at least a 10 percent price advantage for the HMO. All of the people we interviewed said price is a critical factor in plan choice, and at least in southeastern Michigan, some HMOs do enjoy a substantial price advantage. One agent said that the HMOs he sells to employers offer a 25 percent savings over PPO coverage with comparable benefits, and the consequence is that 60 percent to 70 percent of employees choose the HMO over the PPO when the two are offered together.

As noted earlier, the difference between HMOs and PPOs has diminished somewhat. But both agents and health plan officials observed that in some parts of the state, especially southeastern Michigan, HMOs still have an significant price advantage, in part because physicians are paid on a capitation basis, which provides strong financial incentives to weigh costs against benefits when ordering services for patients. They suggested that another factor may be some favorable selection—that is, the tendency for younger, healthier people to choose HMOs over PPOs.

As premiums continue to climb, employers become more concerned with finding ways to reduce their cost burden. When HMOs can offer savings, even if not 10 percent or more, they may become relatively more attractive. But PPOs are increasingly turning to higher consumer cost-sharing as a way to lower premiums. Thus the flexibility regarding cost sharing that was authorized by Public Act 306 may prove to be important in ensuring that HMOs remain competitive.